PUBLIC HEALTH COUNCIL

A regular meeting of the Massachusetts Department of Public Health's Pub lic Health Council was held on Thursday, May 24, 2007, 10:00 a.m., at the Department of Public Health, 250 Washington St., Boston, Massachusetts in the Henry I. Bowditch Public Health Council Room. Members present were: Chair John Auerbach, Commissioner, Department of Public Health, Ms. Helen R. Caulton-Harris, Dr. Harold Cox, Dr. Michèle David, Dr. Muriel R. Gillick, Mr. Paul J. Lanzikos, Dr. Philip C. Nasca, Ms. Lucilia Prates Ramos, Mr. José Rafael Rivera, Mr. Albert Sherman, and Dr. Alan C. Woodward. Absent Members were Dr. Michael Wong and Dr. Barry S. Zuckerman. Also in attendance was Attorney Donna Levin, General Counsel, Department of Public Health.

Chairperson Auerbach announced that notices of the meeting had been filed with the Secretary of the Commonwealth and the Executive Office of Administration and Finance. The Commissioner of Public Health introduced himself and two new members. Dr. Harold Cox, Associate Dean, Boston University School of Public Health and Dr. Michèle David, Assistant Professor of Medicine, Boston University School of Medicine and Co-Director, BMC Haitian Health Institute. The other members introduced themselves to the audience. And further, Chairman Auerbach asked the Secretary of the Public Health Council, Linda Hopkins, to have the April Minutes ready for the next meeting. She agreed. Chairman Auerbach also informed the Council of the series of eight regional meetings he was holding throughout the state. The meeting will allow a public health education dialogue to occur. The Council Members were invited to attend if they wish. Chair Auerbach said he would share feedback with the members regarding the regional meetings.

PROPOSED REGULATIONS: NO VOTE

INFORMATIONAL BRIEFING ON PROPOSED AMENDMENTS TO 105 CMR 170.000, EMERGENCY MEDICAL SERVICES SYSTEM: UPDATE TO PROCESS FOR REINSTATEMENT OF EMT CERTIFICATION:

Mr. Abdullah Rehayem, Director, Office of Emergency Medical Servi ces, accompanied by Atty. Carol Balulescu, Deputy General Counsel, Department of Public Health, presented the proposed regulations to the Council. He provided a quick overview of the proposed regulations.

Staff's memorandum to the Council also explain ed, "The requirements for reinstatement are set out in 105 CMR 170.935 (A). The regulation requires the applicant to submit an application and fee to the Department within one year of the date of expiration of certification; successfully complete a refres her course within that one year prior to the application for reinstatement; and successfully complete both the practical skills and written EMT certification exams. The specific timeline stated in the regulation is that the applicant must complete the pra ctical skills exam within six months of the successful completion of the practical examination. The intent and effect until recently has been

that former EMTs who were applying for reinstatement had one year to successfully pass both the written and practical examinations for EMT certification. Under 105 CMR 170.935 (B), the Department "shall reinstate certification" to applicants who complete the 105 CMR 170.935 (A) requirements. Under 105 CMR 170.935 (C), former EMTs who do not appropriately complete the reinstatement process under the timelines and requirements of 105 CMR 170.935 (A) cannot be reinstated under this process, and must instead complete the full initial certification process in order to become certified as EMTs again."

Staff memo noted further, "The section of the regulation governing reinstatement was written prior to the change made three years ago in administration of the practical skills examination by the Department's accreditation of EMT training institutions. As a result of those changes, the practical skills examination is no longer scheduled and administered by the Department, but rather, scheduled at the initiation of the candidate for examination, and administered by the accredited EMT training institution. Thus, the Department no longer controls or sets the date of the first scheduled practical examination, and has no time limit or even knowledge of when a candidate, after successfully completing refresher training, may decide to make an appointment to take the practical skills examination. This creates the potential for an open-ended process and defeats the intent and long-term operation of the reinstatement process. The effect of this change on the operation of the reinstatement process is just beginning to be felt this year."

Mr. Rehayem stated, "The proposed amendment changes the starting timeframe for successful completion of the practical skills examination from the first scheduled appointment for a practical examination to the date the Department approves the reinstatement application. Thus, the one-year clock for successful completion of the certification examinations will again begin on a date that will be known to and subject to the Department's control, as it was prior to the time the Department amended the regulation to accredit EMT training institutions. This date will also be known to the applicant, who will be informed by dated letter of the approval of the reinstatement application. Thus, the proposed regulatory change will update the process given the recent changes in administration of the practical skill examination, and restore the intent and operation of the reinstatement process."

Staff noted further: (1) that this proposed change was presented to the Emergency Medical Care Advisory Board (EMCAB) for their review and comment as required by section 3 (c) of M.G.L.c.111C. The Department received two comments, one in support of the change, and one with questions about the scheduling of the practical examinations. The Department's proposed amendment remains unchanged following review of the EMCAB members' comments; (2) that the Department intends to hold a pubic hearing on June 27, 2007 to receive comments on this proposed regulatory amendment. Following the hearing, the Department will return to the Council to provide a review of the testimony, to present any changes proposed in response to the testimony, and to request approval for promulgation of the amendment; and (3) to view the entire current version of

the EMS regulations (78 pages) go to the Department's website at http://www.mass.gov/Eeohhs2/docs/dph/regs/105cmr170.pdf .

The proposed change is as follows:
[Strikethrough = deletion; bold = addition or new language]

170.935 Reinstatement of Certification – Amend subsection (A) (4) as follows:

(A) (4) Successfully complete the Department-approved practical examination specified in 105 CMR 179.910 (A)(5) within six months of ~~the first scheduled appointment for a practical examination~~ **the date of expiration of the certification;**

NO VOTE/INFORMATIONAL ONLY

INFORMATIONAL BRIEFING ON AMENDMENTS TO 105 CMR 800.000, REQUESTS AND CONSENT FOR ANATOMICAL DONATIONS:

Attorney Carol Balulescu, Deputy General Counsel, Department of Public Health, presented the proposed amendments to 105 CMR 800.000 to the Council. Atty. Balulescu informed the Council, "…The Department originally promulgated 105 CMR 800.000 to regulate hospital practices regarding the acquisition of consent for donation of organs and tissues. At the time that the regulation was promulgated, M.G.L.c.113,§§ 7 through 14 set out rules to be followed by hospitals seeking to procure consent to organ and tissue donation, and required hospitals to maintain records and report data regarding organ and tissue procurement."

Attorney Balulescu said further, "The Massachusetts General Court revised the statutory requirements in 2005 and 2006.[1] One of the major changes makes duly recorded consent to organ donation irrevocable upon the death of the donor. A second major change recognizes federally qualified Organ Procurement Organizations (OPOs) and shifts the responsibility for requesting consent to organ and tissue donation from the hospital to the OPO. Another change removed the record-keeping and reporting requirements for hospitals."

Attorney Balulescu emphasized that the "Department does not have authority to regulate New England Organ Bank (NEOB) or any other OPOs. Thus, the regulation in its revised format to a large extent merely restates the statutory language as it pertains to OPOs. Because the Department continues to have oversight of the hospitals, the regulation requires licensed acute care hospitals to maintain policies and procedures that are consistent with the regulation."

[1] The original revisions set forth in chapter 145 of the Acts of 2005 contained a typographical error that contradicted one intended change. The General Court therefore enacted chapter 27 of the Acts of 2006 to correct the prior language.

The major changes in the regulation mirror the statutory changes:

- No additional consent is required where there is a record of the donor's intent that was not revoked prior to death;

- The OPO is acknowledged as the designated requestor; and

- There is no longer a requirement that hospitals maintain records and report data.

In closing, Atty. Balulescu noted, "The section for consent was rewritten to use the same language as appears in 105 CMR 130.386 regarding for consent for autopsy and that the Department took this opportunity to better organize the regulation."

Staff noted that the Department plans to hold a public hearing on June 27, 2007. Following the hearing, the Department will return to the PHC to provide a review of the testimony, to present any changes proposed in response to the testimony, and to request approval for promulgation of the amendments.

A brief discussion followed, Mr. Sean Fitzpatrick, Director of Public Affairs, New England Organ Bank answered questions for the Council, specifically for Dr. Cox, who asked "Given that the Department doesn't have responsibility for regulating the OPOs, does the Department lose some oversight authority?"

Atty. Balulescu responded, "We didn't have authority over the organ procurement process as it was. The statute originally required hospitals to follow certain rules when they requested the consent, and that is what this is still about - the consent for obtaining the organs…"

Mr. Fitzpatrick explained further, "…The Legislature, in the 1980s, created a system whereby hospitals were required to be in charge of the request system, maintain all the data, and to report that data back. Since that time the Federal government has completely changed the method by which organ donations are made, and that is, each geographic area of the United States has a specific organ procurement organization. There is no overlap. Every hospital in Massachusetts knows who they are suppose to call when there is a potential organ donor. We have really become the centralized professionals in the recovery of organs and are regulated by the Federal government to do that."

Mr. Fitzpatrick further clarified, "The current regulations in Massachusetts are in conflict with the Federal rules as to what we are supposed to be doing. What these amendments do is clarify the fact that organ procurement organizations (OPOs) are legally responsible for offering organ donation to families and for the record -keeping, and for all the other types of systematic things that need to hap pen to maximize the number of organs available for donation. These regulations reflect the reality of what is going on regarding Medicaid and Medicare participation for hospitals. The

amendments further reflect the new laws here in Massachusetts that went into effect in 2005 and 2006 that recognize the fact that OPOs are now in charge of organ procurement in the state. The regulations are catching up after 20 years of change."

Dr. Michèle David, Council Member asked, "Are OPOs required to make the data available? Mr. Fitzpatrick replied, "We make the information available to the Federal government but anybody needing the information, we can provide it."

NO VOTE/INFORMATIONAL ONLY

DETERMINATION OF NEED PROGRAM:

CATEGORY 1 APPLICATION: PROJECT APPLICATION NO. 4-3B32 OF THE MASSACHUSETTS GENERAL HOSPITAL:

Mr. Jere Page, Senior Program Analyst, Determination of Need Program, presented the Massachusetts General Hospital application to the Council. He said in part, **"**The applicant, The Massachusetts General Hospital is before the Council today seeking approval for substantial new construction and renovation of the hospital's campus in Boston. This project involves new construction of a ten-story (14 levels) addition adjacent to the existing hospital. By the 14 levels, four will be underground and ten will be above ground. The purpose of this construction is to increase the hospital's medical/surgical capacity from 676 beds to 804 beds, and increase critical care capacity from 109 to 131 beds. Construction of the new addition will also allow the hospital to increase its surgical capacity from 52 operating rooms currently to 71, as well as add space for certain ancillary and outpatient services, and a variety of support services. A renovation of existing space will allow perioperative area, and to do a preoperative ambulatory care unit, among other things, as well as connect the new addition to the existing hospital campus. It is expected that this entire project will be completed by October of 2011."

Mr. Page continued, "This project is intended to correct a number of functional and physical inadequacies inherent in the hospital's existing space that hinders its ability to meet the growing needs of its medical/surgical, critical care, and surgical patients, as well as accommodate changes in medical equipment and technology in order to provide state-of-the-art services. Staff agrees with MGH that the proposed new medical/surgical intensive care and ORs will be better designed to optimize patient care and staff access to ensure operational efficiencies. The recommended maximum capital expenditure for this project is $498,044,698 (November 2006 dollars). This project will be financed in two ways: 1) equity contribution of 91.5 million dollars from the hospital's available funds including fund raising and accumulated gains from operations and 2) the remaining $406.4 million dollars will be funded by tax exempt bonds issued by the Massachusetts Health and Educational Facilities Authority (MHEFA). The interest rate is fixed at 5% for a 35 year term."

In regards to community health initiatives, Mr. Page informed the Council, "MGH will provide $18.6 million dollars over a maximum of seven years to fund 27 community health service initiatives and programs that target a number of disparities: 1) racial and ethnic health care disparities, 2) substance abuse and violence, 3) improved access to care; and 4) and increased educational employment opportunities for Boston public school students."

In conclusion, Mr. Page said, "Staff is recommending approval of this project with the six conditions listed on page 27 and 28 of the staff summary…"

Chair Auerbach requested that the Council Members who have a conflict of interest or perceived conflict of interest note it for the record. Dr. Woodward, President of Emerson Hospital Emergency Physicians noted, "Though Emerson is an affiliate of MGH. I feel I can render an objective opinion on this topic." Dr. David, Assistant Professor of Medicine, Boston University School of Medicine said, "I am a staff physician at Boston Medical Center and to avoid the appearance of a conflict of interest, I recuse myself." Dr. David did not participate in the discussion or vote on this project. Mr. Sherman noted, "I do not derive my income from the University of Massachusetts Medical School so I feel I have no conflict or perceived conflict…"

Peter Slavin, M.D., President of Massachusetts General Hospital addressed the Council. Dr. Slavin noted that the hospital was founded by the Commonwealth of Massachusetts in 1811 for poor patients who had no homes for doctors to visit them in and so MGH provided them free care at that time. He said, "That history plays a very important factor in the culture of this organization and our commitment to serving all segments of society. We have a proud legacy of caring for all people, regardless of their ability to pay. We are the third largest provider of care to the uninsured in this Commonwealth, behind Boston Medical Center and the Cambridge Health Alliance and for the last 40 years, we have operated community health centers in Charlestown, Chelsea, Revere and more recently, the North End. I am never more proud of the hospital than when I visit these facilities and see the great care that is offered to people in those communities in those health centers." Dr. Slavin showed the Council a schematic of the future building.

Dr. Slavin noted, "I am very pleased to be viewed as a leader in health care in a number of areas, but one of the areas that we are not pleased to be a leader in is the Emergency Room divert hours in this City. One of the most important reasons for moving forward with this building is to help us dramatically decrease the amount of divert hours that we are dealing with on a day-to-day basis, and I would like Dr. Conn to elaborate on this."

Alasdair Conn, M.D., Chief of Emergency Services at MGH, testified before the Council. "If you ask me what keeps me awake at night, it is the fact that we have overcrowding in our Emergency Department and these are patients that have been seen and we have determined that they need to come into the hospital, but there are no beds available."

Dr. Conn noted further, "This morning when I arrived at work, we had 17 patients waiting for inpatient beds. On a normal day, we have 25 to 30 patients waiting. I only

have 44 beds. On a typical day, we may have 220 to 250 patients come into the emergency room, we will admit 60 patients. We will admit the additional 15 to our Observation Unit but it is very cramped."

In closing, Dr. Conn stated, "…Emergency Department overcrowding is not an Emergency problem it is a hospital capacity problem…Of all the people in support of this project at MGH, I am the one most in support because it will add inpatient beds so that those patients deemed to be emergency admissions will have a better stay and we can manage them better."

Joseph Betancourt, M.D., Director, MGH Disparities Solution Center , addressed the Council. He said in part, "…I have been at Mass General now for six years and it has truly been an honor to participate in this wonderful organization. The vision of leadership has made me very proud, the commitment to diversity, equity, and community is very impressive, and I don't use those words lightly, nor would I sit here and say them if they were not true…In response to the Institute of Medicine Report and the Mayor's effort on disparities, I think our hospital has really made a very significant commitment to address these issues of disparities, not only within the four walls, but also in the communities where these issues really take root. Our committee on Racial and Ethnic Disparities has developed ways to identify and address disparities so that this set of activities won't just be developing resources for the community, but we want to make sure that what goes on within the four walls of our hospitals are really centered around equitable care and quality of care for all patients we see, regardless of their race, ethnicity, culture, or class."

In regards to the community initiatives, Dr. Betancourt said, "The process that we have engaged in, in identifying targets, was done and will continue to be done in a community-based effort, I think which speaks to the importance of how we have ascertained these target areas: substance abuse, HIV/AIDS, youth violence, mental health, homelessness, pipeline issues and other public health initiatives, all linked to the heart of disparities, and are in line with the state and city blueprints to address disparities that are currently in place. It is important to note that these commitments don't begin in 2011, they begin now…I want to reiterate the point that the leadership, vision and infrastructure is really in place to make a huge difference in the community, as well as in the new building, and in the rest of our hospital. We have a tremendous window of opportunity for action. This proposal is, in many ways, ground breaking, and will improve community health and address disparities. I hope you agree to support it…"

Ms. Carol Tye, Revere CARES (Community Assessment Resources and Education to Prevent Substance Abuse) Coalition. Ms. Tye noted that she taught for 35 years at Revere High School, was Superintendent of Schools for seven years and is now retired. Currently she is an elected member of the Revere School Committee and is very active with Revere CARES. She speaks today as a member of Revere CARES. She said in part, "…Ten years ago, the leadership at MGH came to us and asked , 'What is your most pressing health care concern.' It was clear that it was substance abuse among our youth. We conducted a survey of parents and key stakeholders…MGH first gave us money then

a Director and supported us all the way. It has supported us financially but it is also the leader in grant writing, which is so important to us, research and education. Almost anything we need, they look at and help us to get it. We are making measurable progress in addressing our substance abuse and, as a result we are a more cohesive community…In the beginning, people believed that substance abuse was the school's problem. No one believes that anymore. Everyone knows we must all work together if we are going to protect our youth from substance abuse. The funds in this package will allow us to implement our strategic plan which is (1) to increase opportunities for physical activity among youth, and (2) assess young men's health and families and (3) after school partnership and programming. We couldn't have done it without MGH. We know resources will be implemented."

In summary, Dr. Slavin said, "…We hope that you agree with us, that this building and these community health initiatives have the potential to improve the health of the people in this region for many years to come, and we certainly hope that you will support this initiative."

A discussion followed and some of the questions and comments are below (Note: For complete discussion see the verbatim transcript of the meeting).

Dr. Woodward, Council Member asked about the Emergency Room diversion problem at MGH – "Are there any specific targets on reduction of the Emergency Department crowding, boarding and ambulance diversion…?

Dr. Slavin responded that the hospital has a committee that includes chiefs of the departments that meet every two weeks to work on solutions for the ER. He said, "Those include trying to work with our primary care physicians to keep patients out of our Emergency Room, and perhaps consider sending them to other emergency rooms. It includes trying to enhance the services that are available in the Emergency Room and so now we have a laboratory there 24/7. We are the first hospital in the nation to have an MRI in the Emergency Room. We are bending over backwards, to try to get patients up to the beds as quickly as they are available, and recently installed a new electronic system so that the ER is aware instantaneously, as soon as a bed is ready and has been cleaned. We are taking all the steps we can under our current environment…We have made some modest progress but we haven't seen a decrease in the number of the boarders but the boarders are spending less time in the ER than they were previously. We continue to work hard on it and hope to make further progress, but there is nothing in our quiver as potent as this project."

Discussion continued about the ER diversion. Dr. Conn, Chief of Emergency Medicine at MGH noted that they have short term goals in terms of the number of boarders that may stay in the ER. He said, "…The real goal is to abolish all boarders. The short term goal is four hours maximum per patient. That would include the work-up, the CAT scans, the report to the floors, and getting the patient upstairs, and recleaning that stretcher bay. Our length of time for a bed has been shorted. Our worse month was

September with a wait of 11 hours. We are now at about eight hours and we are pushing for six and then down to the four hours and eventually no boarders."

Council Member Woodward added in part, "…MGH has been one of the most frequent on diversion, and it is a trickle down effect. One hospital goes on diversion, and others reactively have to go on diversion, and we all know it compromises care in a serious way, and everyone has had experiences where care of their family or their neighbors h ave been delayed as a result of the problems we have in our emergency departments, and not unique to Massachusetts, obviously, but across the country and, in fact, it has been an international problem, but it is clear that it is an outflow problem, it is a n in-hospital capacity problem, and inpatient capacity problem, and flow problem, and how do we pull out all the stops to fix this as soon as possible…"

Dr. Conn further responded that they are working with community centers and physician groups to advocate that patients go to other partner hospitals with simple matters such as pneumonia or appendicitis to help alleviate the problem. He also said, "When one gets to the age of 65 years - the baby boomers will be at that age in the years 2010 -2012. That is going to be an issue for the entire health care system."

Council Member Helen Caulton-Harris inquired about their medical interpreter programs and would they be able to meet the condition's target of 120 days?

Dr. Slavin responded, " I presume so. We h ave an outstanding department, Interpreters Department, that translates in dozens of languages, and I presume that they are aware of this requirement and will respond promptly."

Ms. Brunilda Torres, Director, Office of Multicultural Health, Department of Public Health addressed the Council. She said, "… On prior occasions, with prior DoN submissions, we have worked with Interpreter Services as a way on continually developing facility-specific interpreter services. In the past, they have always been able to respond within a 120 days. My expectation is that they will do the same in terms of their plan…I have in the past, received their timely submissions and have been in contact with them often….The Manager of Interpreter Services there, Mr. Sanchez, has a large vision and they work really hard adapting the strategies of providing language access within their complex, and has come up with some unique ideas specific to clinical care…"

Ms. Caulton-Harris stated, "As we look at the demographic shift, I just t hink this is a very important part of the work that we are going to do futuristically. To assure that the plan will be forthcoming make me feel better."

Council Member Lanzikos noted, "I commend you on your sensitivity to the public health from an environmental perspective, by your commitment to building standards. I think that is a lead that all future applicants should follow very closely….How much have you anticipated within the construct of the new building, that you are building to adapt to

change without significant major alterations, both in terms of the physical construction and the way you operate the building?"

Dr. Slavin responded, "First, we have designed this building with the baby boomers in mind. All of the rooms are private rooms. All of the rooms have facilities for family members to spend the night, which is obviously dramatically different from most facilities that would have been built in the past. Secondly, adapting the building to future technologies will be as flexible as possible…Floor to ceiling heights are being designed in such a way that more air handling, more cables, more wires could be run through the infrastructure in the future than will be done in 2011. We are trying to build this building in a way that it can adapt to changes in health care as best as possible in the future."

Dr. Muriel Gillick, Council Member inquired about the anticipated expenditures that will be required to deal with the potential construction nightmare.
Dr. Slavin said that MGH has a committee working on how to keep the hospital and Mass. Eye and Ear Infirmary next door fully functional during the construction period.

Dr. Harold Cox, Council Member noted that he was grateful for so much attention to the baby boomers, being one of them. He also, asked for clarification on when the community initiative payments would be made (page 28 of staff summary). Ms. Joan Quinlan, Director of Community Benefits and Dr. Slavin clarified that the numbers, five, seven, and so on mean the payments will be made over that many years and the phrase, "Upon DoN Approval" means that MGH will pay the entire amount immediately.

Chair Auerbach asked Dr. Slavin to speak about the green building aspects of the project. He said, "If I could return to the question that was raised about the Green building construction process. I think that is something that the Council is going to be looking at and working with the Determination of Need Program to consider for future major capital construction. Could you talk a bit about that in terms of the components of what it means to have a Green building, the challenges that presents in terms of a hospital, and maybe some about cost."

Mr. David Hanitchak, Director of Planning and Construction, MGH, responded "…Health care is one of the more difficult elements of construction types to bring a fully Green agenda to. Partly, we have got 24 hour care. We have high intensity of infrastructure, utility use, lots of chemicals, a very difficult situation. There is a LEADS Program and a Green Guide for Health Care Programs. We are looking for a Silver level of commitment on this building. There is a check list on all aspects. For instance, for transportation, we have zip-cars…It is difficult. We are beginning to see the development under the Green Guide system emerge with the LEADS…My best guess; we are probably spending on the order of six million dollars to achieve what we are doing. Not the least of that is: Green roofs, bringing more plant material, recycling waste water, and recycling rain water to the system as best we can."

In closing, Mr. Hanitchak stated, "The hospital has always had a strong commitment, if only in its own interest, to minimize energy use, has worked and has won awards on that

over the years from various mechanical and electrical engineering associations, and from the City, as well. There is a strong commitment on the part of the hospital to achieve the goals. We have spent a lot of time managing that. As you also know, I am sure, it is an ongoing process. It is a certifiable process. We have to demonstrate we have achieved it. We have to demonstrate we are continuing to achieve it when the building is under operation."

Council Member Sherman moved approval of the project. After consideration, upon motion made and duly seconded, it was voted unanimously (Council Member Dr. Michèle David abstained) to approve **Project Application No. 4-3B32 of the Massachusetts General Hospital,** with a maximum capital expenditure of $498,044,698 (November 2006 dollars) and revised first year incremental operating costs of $78,322,500 (November 2006 dollars). A staff summary is attached and made a part of this Record as **Exhibit No. 14,883**. As approved the application provides for construction of a ten-story addition adjacent to the exiting hospital to increase the hospital's adult medical surgical capacity from 676 beds to 804 beds (addition of 128 beds) and increase intensive care capacity from 109 beds to 131 beds (addition of 22 beds). Construction of the new addition will also allow the hospital to expand its surgical capacity from 52 operating rooms to 71, as well as add space for certain ancillary and outpatient services and a variety of support services. Renovation of existing space will allow MGH to develop a centralized procedural intake and perioperative area and add new preoperative ambulatory care unit (PACU) and to connect the new addition to the existing campus. This Determination is subject to the following conditions:

1. MGH shall accept the maximum capital expenditure of $498,044, 698 (November 2006 dollars) as the final cost figure except for those increases allowed pursuant to 105 CMR 100.751 and .752.

2. The total gross square feet (GSF) for this project shall be 489,966 GSF: 411,284 GSF including 2,672 GSF for shell space, for new construction to add medical/surgical and intensive care bed capacity, increase operating room capacity, and add space for certain ancillary and outpatient services, as well as a variety of support services; and 78,682 GSF for renovation of existing space to, among other things, develop a centralized procedural intake and perioperative area and add a new PACU, as well as connect the new addition to the existing campus.

3. MGH may build 2,672 GSF of shell space on the sixth level of the new addition, if it does not claim reimbursement for any depreciation or interest allocated to such space unless and until MGH (1) devotes this space to health care activities, and (2) obtains DoN approval, if required for its buildout. Under current law, DoN approval would be required if (1) the cost of finishing any floor of the shell space plus the portion of the cost of the shell space allocated to the floor is at least equal to the applicable DoN capital expenditure threshold or (2) the proposed use of such space meets the

requirements for a substantial change in service.

4. MGH shall contribute 18.4% in equity ($91,552,334) in November 2006 dollars) to the final approved maximum capital expenditure (MCE).

5. With regard to its interpreter service, MGH shall:

    - Update its policies and procedures to include use of only trained interpreters, and to require face-to-face interpretation as the preferred mode for interpretation services.

    - Ensure the availability and quality of timely interpreter services at all clinical sites operating under its license.

    - Continue ongoing training for all Hospital clinical staff on the appropriate use of interpreter services.

    - Include the Interpreter Services Manager in all administrative decision-making processes that affect people with Limited English Proficiency (LEP).

    - Develop a comprehensive plan to inform LEP community members and agencies identified in HSA IV area about availability and provision of interpreter services at no cost at MGH.

    - Enhance its tracking mechanism system to comprehensive monitor and assess completed patient interpreter requests.

    - Continue to post signage that informs patients of the availability of interpreter services at no charge in the Emergency Department and at all key points of entry into the Hospital. Signage must be available in the primary languages identified by the Hospital's language needs assessment.

MGH shall submit a plan to address these interpreter service elements to the Office of Multicultural Health (OMH) within 120 days of DoN Approval, and shall provide Annual Progress Reports to OMH within 45 days of the end of its Federal Fiscal Year. In addition, MGH shall maintain current efforts to provide access to competent interpreter services to LEP patients, notify OMH of any substantial change to its Interpreter Services Program, and provide to OMH a copy of its annual language needs assessment. Further, MGH shall follow recommended National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health Care. In addition, MGH must develop a plan on how the Hospital will use the data it collects on race and ethnicity to address racial and ethnic health disparities.

MGH shall provide a total of $18,600,000 (November 2007 dollars) over a maximum of seven years to fund the following community health service initiatives described previously:

Community Initiative	Total Amount	Years Funded
Revere CARES	$1,400,000	Seven
Chelsea: Violence Prevention Action Plan	750,000	Seven
Chelsea: \Middle School Initiative	750,000	Five
Wintrop: Community Against Substance Abuse	500,000	Seven
Charlestown: Charlestown Recovery House	2,000,000	Upon DoN Approval
Charlestown: Expanded Substance Abuse and Mental Health Services	1,000,000	Five
North End Community Health Initiative	500,000	Five
East Boston Neighborhood Health Center	1,650,000	Five
Meeting the Needs of Seniors in the West End/Beacon Hill Neighborhoods	1,800,000	Seven
Boston: Mental Health	2,500,000	Seven
Boston: Barbara McInnis House	250,000	Upon DoN Approval
Boston: School Partnerships/Workforce Development	1,500,000	Seven
Pathway to Wellness	250,000	Upon DoN Approval
Boston Living Center	300,000	Three
Massachusetts League of Community Health Centers	500,000	Five
Boston: Urban Youth Sports	220,000	Three
Boston Public Health Commission	500,000	Five
Harbor Community Health Alliance	50,000	Five
Boston Alliance	250,000	Five
United Way of Massachusetts Bay	200,000	Five
Boys & Girls Clubs of Boston	200,000	Five
Boston: 74 Joy Street	30,000	Upon DoN Approval
Critical Mass	50,000	Five
Massachusetts Partnership for Healthy Communities	400,000	Five
Greater Boston Center for Healthy Communities	100,000	Five
Summer Alternatives for Boston Youth	100,000	Upon DoN Approval
Management and Evaluation	850,000	Seven
Total	$18,600,000	

Staff's recommendation to the Council of approval was based on the following findings:

1. MGH proposed new construction of a ten-story (fourteen levels) addition adjacent to the exiting hospital to increase its adult medical/surgical capacity from 676 beds to 804 beds (an addition of 128 beds) and increase intensive intensive care capacity from 109 beds to 131 beds (an addition of 22 beds). Construction of the new addition will also allow the hospital to expand its surgical capacity from 52 operating rooms (ORs) to 71 Ors, as well as add space for certain ancillary and outpatient services and a variety of support services. Renovation of existing space will allow MGH to develop a centralized procedural intake and perioperative area and add a new preoperative ambulatory care unit (PACU), among other things, as well as

connect the new addition to the existing campus.

2. The health planning process for the project was satisfactory.

3. The proposed new construction and renovation is supported by MGH's need to accommodate an increasing and complex patient caseload, as discussed under the Health Care Requirements factor of the staff summary.

4. The project, with adherence to a certain condition, meets the operational objectives factor of the DoN Regulations.

5. The project, with adherence to a certain condition, meets the standards compliance factor of the DoN Regulations.

6. The recommended maximum capital expenditure of $498,044,698 (November 2006 dollars) is reasonable compared to similar, previously approved projects.

7. The recommended incremental operating costs of $78,322,500 (November 2006 dollars) are reasonable compared to similar, previously approved projects.

8. The project is financially feasible and within the financial capability of the applicant.

9. The project meets the relative merit requirements of the DoN Regulations.

10. The proposed community health service initiatives, with adherence to a certain condition, are consistent with the DoN Regulations.

11. The Donald G. Bellefeuille Ten Taxpayer Group (TTG) registered in connection with the proposed project, but did not submit written comments or request a public hearing.

STAFF PRESENTATION:

"Commissioner's Report: Strategic Direction for DPH", by John Auerbach, Commissioner, Massachusetts Department of Public Health :

Commissioner John Auerbach made a report on his planned strategic direction for the Department of Public Health. He said in part, "…This is a presentation for the Council Members about some of the initial approaches that I will be making, and that other members of the new team at the Department will be making in the coming months …" I think it is important to share this information with the Council since some of the matters that you will be considering in the coming months will relate to some of the items that I am going to be highlighting…"

The six initial strategies that the Department will be employing in the coming months are:

- Holding series of community meetings around the state
    - With the use of health information and input from community residents establish a list of top priority initiatives for the Department.
- Will come back to the Council with the list of top priorities
    - Shift focus of Department to reflect those priorities identified
    - Policies and programs of Department be based upon scientific and evidence-based processes
        - Part of that being the establishment of the new Public Health Council
        - Governor and Legislature would like the Council to operate, insulated from political decision-making and focus on the issue of what is in the best interest of the health of the residents of Massachusetts
        - New Council constitutes more medical and clinical health experts
        - New Council will be looking at cutting-edge or new initiatives that may be controversial in terms of substance abuse, HIV, and infant mortality
        - DPH staff is looking at these issues nationally as well as within the Massachusetts communities
- Loss of DPH funding since 2001
    - Highlight good work of staff to rebuild internal morale and expertise
    - HIV and substance abuse programs cut by more than 30%
    - Restore program funding
        - Actively and aggressively work for increased resources
        - More visible role at the State House

        - Creation of Director of Legislative Affairs whose job will be to establish strong relationships with the Legislature and ensure that they are well aware of the work that occurs within the Department and further to respond to their requests for information relating to their constituents' concerns

        - Aggressively pursue Federal funding and private funding

            - Creating a Development Office to research funding possibilities and assist Department programs with writing grants

            - Seek new partnerships with other institutions working on health issues such as hospitals, universities and health care organizations to meet common goals

- Increase visibility of Public Health in Massachusetts

    - More Staff presentations held in the communities and public settings

    - Release of strategic reports that reflect Department priorities and key health concerns

        - Release of a separate health data report for each region of the state (released over the course of the next 45 days). The most comprehensive report on health in each region ever prepared.

    - Creation of Office of Communications to ensure that public information campaigns are visible and professionally prepared and also to highlight programmatic activities and health concerns in a more professional manner.

- Strengthen partnerships with local municipal health departments and agencies across the state

    - Local health departments respond to a wide variety of health concerns usually with inadequate resources therefore the Department is thinking about both policy changes and funding decisions which will increase the likelihood of those local health departments to be able to respond appropriately

    - Possibility of establishing a regional health system within Massachusetts - an intermediary type of organization that would cluster together some of the local health departments and ensure that they have adequate resources through the use of that clustered organization. It was noted

that Council Member Harold Cox has been involved in this effort with a broad coalition of organizations, including the Legislature in exploring the possibility of a regional health system.

- Working closely with Community Health Centers
    - Play critical role in clinical care and public health activities
        - Recognize their expertise with diverse populations that require population-specific and language-specific organizations who know how to reach populations at the greatest risk for public health concerns within the State.

In summary, Commissioner Auerbach stated, "We will honor our commitment to accomplishing that. Within 60 days, we will both have completed the eight regional meetings, and we will have established a short list of priority initiatives for the Department. We have already begun to alter the organizational structure of the Department, to reflect some of the new priorities of the Department, and we will have those processes completed within the next thirty days. We are creating, as I indicated, these three new organizational units of Communications, Legislative Relations and Development. We will be focusing internally on the areas where immediate attention for leadership and support is required, and will be doing a variety of different activities to strengthen our external partnerships with organizations around the state, with a focus on local health departments and community health centers, and with an eye to the current regionalization planning activities."

Discussion followed by the Public Health Council:

Ms. Helen Caulton-Harris stated in part, "I am particularly happy to see the local health state health partnership flourish and develop. I am also, always concerned about geographic parity, as I live in the Western part of the State. I am happy to see that as part of your plan and I truly look forward to being a partner as you operationalize this important work. I want to congratulate you and thank you for presenting what I believe is a foundation that we can move forward on."

Dr. Michèle David, I also want to congratulate you on this. I particularly want to point out the local partnership. One of the strengths that I have seen, way back when I first started at Boston Medical Center was, on a community board, was some of the CHNA Initiatives that have been really helpful in building community-based organizations, and as the dollars have lessened a lot of those organizations have been weakened. I am really looking forward to perhaps some strengthening again with the local ties."

Mr. José Rafael Rivera, "Impressive and a few of the things touch upon community expertise and knowledge and where the communities are and I want to offer, as a member of the board, my commitment to work with you as a community health worker…I am looking forward to more conversation."

Paul J. Lanzikos, "…I applaud you – not only with the breadth and depth of your vision here but with the clarity of your plan of execution…I would hope that this notion of collaboration and reaching out extends to others within State government, so the agendas are compatible and synergistic because we don't want you to be doing this alone…I would encourage you to share this with your peers in other agencies – not just the content but the process because I think some of the other agencies could similarly be generated in terms of the broader public mission."

Dr. Alan C. Woodward, "I would also like to compliment you on having a clear road map, as least to the initial visions of a clear road map and I think that has been lacking in the past and a clear commitment to a scientific base and a political base for Public Health in this Commonwealth is essential. I do believe that coalitions and breaking down the silos is going to be imperative. I would also concur strongly with the concept many states have county-based health systems or regionally based systems, and 351 towns, many of them with a single part-time public health officer, can in no way deal with the complexities of the public health threats and public health implementation programs that need to be expected in this day and age. I think the Council would be very interested in hearing Harold Cox's presentation, figuring out how we can enhance that, and move forward on that, as well as building alliances because, clearly, there are many potential alliances to be reinforced again in this Commonwealth and built upon going forward, and I think public health in the Commonwealth has its proud history, and has tremendously positive future if leveraged properly, which I think everyone in this room understands the importance of and should be committed to."

Mr. Albert Sherman, "John, I have been here since Bicknell to Cote. They are gone. You are the first, other than Deborah Prothrow-Stith. You are the first Commissioner who has had a vision about doing something like this. You ought to be very proud."

Philip C. Nasca, Ph.D., "I am very pleased to hear you talk about the idea of partnering with hospitals, with universities, the idea of having a science base and an evidence-base for moving public health forward. One issue, I would like you to give some thought to, over the next few months, is the mechanism for maintaining confidentiality when, at the same time, not putting the strangle-hold on the flow of data, and I quite frankly, will tell you that I think, in the past, there has been a situation where it has been difficult to develop these collaborative relationships when, in certain cases, there has been a value to having a reasonable way to maintain confidentiality but to be able to share data for legitimate research and evaluation, and I think that should be high on the agenda."

Chair Auerbach responded, that the new director of policy and planning, Kristin Golden is working with the DPH research and evaluation data collection departments "to more seamlessly share information, being mindful of confidentiality, but to have data be more accessible to partners and to the public and presented in a way that is more useful in terms of addressing the ultimate outcome of improving health. We will be seeing policy changes over the coming months in an attempt to do that in a more collaborative way."

Dr. Nasca responded, "I think that is great and will go a long way to help in enhancing the state, local and university health department collaborations."

Dr. Muriel R. Gillick, "Thank you for your very thoughtful presentation. I am struck, though, that it is, of course, a good idea to use scientific -based methods, but that there is a fundamentally value-based piece here, which involves the prioritization of the goals, and while your point #1 involves identifying priority areas, I wonder if you could comment, in one minute or less, on how you plan to go about prioritizing those goals."

Chair Auerbach responded in part, "I think that is a good question. My inclination is to rely primarily on two sources of information. The first is the incredible wealth of health information that is collected by the Department and see the trends that emerge in terms of what is different now than 10 or 20 years ago (Obesity and Asthma for examples). Secondly, is to really listen to what people closest to the communities tell you are the health concerns in their communities. Sometimes the data fails to capture some critical issues….So, combining those two, what do we hear from the communities and comparing that to department data, I believe that will suggest a few areas that are very compelling in terms of the need to prioritize…" Chair Auerbach further said, "I would welcome some feedback from others who would look at the same information and say, hey, you left out some things. You may need to rethink that list."

Ms. Lucilia Prates Ramos, "…I would like to thank you for your bullet that says that you are going to rely upon the expertise within the diverse community and hold the regional meetings and listen to our communities …"

Dr. Harold Cox, "…We will make this unanimous in the love fest here and briefly just thank you for your leadership. This is exactly the right thing we should be looking at…."

In closing, Chair Auerbach stated, "I feel like these really came out of work that people have done. This is really speaking to much work that has been done, including by Members of the Council and people in the communities, to highlight those core issues. I feel like I am, in part, reflecting back that, and we will come back to you within the period of time that we have pledged with the feedback from the community meetings, and the short list of priorities, and then maybe we can continue the discussion about is this the right list and what are the implications of agreement to this."

The meeting adjourned at approximately 11:42 a.m.

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John Auerbach, Chairperson

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